Los Angeles at that time, with a population of 80,000 people and 200 registered physicians, was represented in the State Society by only eleven members, its County Society consisting of forty members.

At that time our State Society was largely a San Francisco organization, the result on the one hand of difficulty of travel from place to place, and on the other of the rather loose general organization which failed to bring the more distant members in direct association with the State Society.

According to our present Secretary, at the time of the reorganization of our State Medical Society on the American Medical Association basis in 1904, the membership was about 300, or some fifty less than it was twenty years previous. As a result of the reorganization on the county unit basis, the membership increased to 1575 in 1905, which number, according to the register of 1906, has since increased to 1821, the total number of registered physicians of all schools being 4023.

There are some 57 counties in California, and in only 36 of these are County Medical organizations, leaving 21 counties, or about 33 per cent. without any direct representation in this Association. Here then is a fertile field for present and future work in extension.

Not to be forgotten also, is the intensive growth or increased development of the county medical associations already in existence. The beneficent effects to county medical units of organization on the American Medical Association basis is well shown in the history of the Los Angeles County Medical Association. Before its reorganization some three years ago that organization was leading a precarious existence, having a membership of about forty and holding monthly meetings at which there was an average attendance of about fifteen to twenty. Today that same society has a membership of almost 400 members, maintains weekly meetings in the city of Los Angeles, with an average attendance of 55 to 65, has two sections in the specialties, and is credited with three prosperous branches in nearby cities. Since the beginning of this year more than twenty members have been added to the membership roll, and the campaign is on to enroll every eligible practitioner of non-sectarian medicine in the county.

What has been responsible for this remarkable growth? Largely the fact that the county medical unit, with associated membership in State and national organizations, is the logical basis of any rational and comprehensive scheme of medical organization.

It is an old saw which says, "Nothing succeeds like success," and nowhere does the saying apply with more force than in medical organization work. Each new society, and each additional meeting or section in a specialty or in a nearby town, benefits not only the immediate membership, but acts as a reflex tonic to all other phases of organization work.

To recapitulate concerning Medical Organization and Public Health Work:

There is annually a vast and unnecessary sacrifice of life owing to the fact that an ignorant or uninformed laity, or vicious vested interests, prevent the public health legislation which the medical profession knows should be on our statute books.

The medical profession fulfills its highest functions to humanity and the state when it prevents unnecessary disease and death.

If the medical profession of California would have brought into being and enforced the public health legislation which we know should be among our laws, more disease would be prevented, and more lives would be saved to our State, than we will be able to credit in all probability to the increased amount of scientific facts which will be added to medical and surgical knowledge during the coming year.

This public health legislation can be brought into existence only when an organized medical profession educates the public in regard thereto, so that public opinion will be so great that the politicians will be only too glad to give the people what they want.

A united and organized medical profession will, however, do more than this. It will induce also a greater scientific development than can be existent in an unorganized profession, and this because, in a condition of disorganization, only the true students strive after increase of scientific knowledge, whereas in the organized profession, the influence of these students and the effect of association with one's professional fellows is such, that the striving for intellectual and scientific progress becomes general, all who come within the sphere of the organization influence being benefited.

Organization means, then, more disease prevented, more lives saved, a more scientific, and a more fraternal and a more prosperous medical profession; in fact, the very things which are the ideals for which we should and do stand.

Is not, then, the perfect organization of the medical profession of California the paramount question and issue before us?

SYMPTOMS AND DIAGNOSIS OF HIP JOINT DISEASE.

By P. C. H. PAHL, B. S., M. D., Los Angeles.

Hip Disease in the Infant—We have four distinct varieties of hip joint inflammation; the tubercular, gonorrheal, syphilitic, and inflammation following the various acute infectious diseases and other organisms.

In early infancy, tuberculosis is very rare and an inflammation of the hip joint at that period of life practically excludes it. Gonorrheal inflammation usually follows in the steps of opthalmia neonatorum, urethritis or vaginitis; there are cases on record where the joint discharges were proven to be gonorrheal. The infection was thought to have entered the general circulation through a gonorrheal stomatitis or infection through the air passages. The symptoms are very acute pain, swelling, restricted motion and mal position.

The syphilitic variety, sometimes termed pseudo-

paralysis, has an altogether different clinical picture. The swelling is usually well marked, some pain and interference with mobility, but no rigidity; the limb hangs motionless and limp to such an extent that the condition has frequently been mistaken for anterior polio myelitis. In the syphilitic variety anti-leutic measures do wonders and are a factor in the diagnosis. If the diagnosis is not made, however, the condition invariably leads to suppuration and destruction of the joint. In later life, one frequently recognizes these cases by the peculiar white bulging and ragged scars, shortening and mal position of the limb, due to contractures.

In those cases in which the pneumococcus, bacterium coli, streptococcus and other organisms are found, the symptoms are very similar to the gonorrheal variety, but much less virulent in nature. In this and the gonorrheal variety the symptoms usually abate in from one to two months' careful treatment on a Bradford frame with slight elastic traction; there may, however, in two to four weeks after the onset, be a slight evacuation of a cero purulent discharge of the joint. These cases will have to be carefully dressed with mild antiseptic packs in conjunction with the Bradford frame treatment. The mortality is very high and a grave prognosis should be made.

It would be an easy matter to imagine the bacterium coli to be responsible for many cases, for it is more than probable that frequently the hip joint receives a trauma during a difficult labor, which would make a very suitable soil, if there should exist an auto infection due to some digestive disturbance which so frequently exists in the new born.

Hip Joint Diseases in Children—I have observed several cases of hip joint disease in children, following parititis, which proved to be non-tubercular. Tubercular hip joint disease occurs almost entirely in walking children.

The symptoms of hip joint disease are obscure and are frequently mistaken for what are called growing pains, rheumatism, knee joint disease, or even a poorly fitting shoe. They consist of lameness, pain, induration about the joint, limitation of motion and slight general constitutional derangement. As the case becomes somewhat advanced there is an apparent lengthening of the limb, muscular atrophy and, frequently, night cries. The child guards the foot of the affected side with the well one, and cries when any one attempts to move it.

When the child is placed upon the table with both legs side by side and extended, a tilting of the pelvis is almost always present and is recognized by the arching of the lumbar spine. In early cases there may even be some question as to which limb is affected; this can usually be readily decided by raising first one knee and closely observing if there is any change in the position of the lumbar spines; if you raise the knee of the healthy limb there will be no change in the arched condition; if you place your thumb and fingers on the two anterior superior spinous processes you will find that the healthy limb can be moved in any direction without changing in any way the position of the pelvis. In the normal state you can place the heel of the healthy leg over the opposite hip joint. By placing one hand over the well joint in such a manner that the fingers grasp the posterior and upper part of the femur, the thumb just outside of the brim of the pelvis midway between the spine of the pubes and the anterior superior spinous process, and placing the other hand on the flexed leg, just below the knee, directing the patient to relax all the muscles as much as possible, reassuring him that you are not going to hurt him, it is possible, upon gaining the confidence of the patient, to get a very accurate idea of the normal amount of thickening of that particular child's hip joint, and you can readily determine the normal excursions of the head and neck. By alternately pushing and pulling with the hands upon the flexed leg, the laxity of the joint may be observed, a most valuable symptom in congenital dislocation as well as in those cases of tuberculosis where the head has become dislocated or where an epiphyseal separation has taken place.

Now let us examine the affected limb. We notice by carefully raising the knee that the arched condition of the spine immediately disappears. If we place the thumb and fingers on the anterior superior spinous processes and attempt to move the hip joint we find that the pelvis follows every movement of the thigh. If we again place the leg in an extended position on the table, the arching of the spine reappears. We examine the joint with one hand placed as before, the thumb outside of the brim of the pelvis, the fingers grasping the greater trochanter and posterior part of the joint, the other hand on the flexed leg; if the case at hand is a case of tubercular hip joint disease there will be perceptible changes which can be felt about the joint, such as induration, a general thickening or fluctuation. If the femur can be moved at all, the excursions of the head will be very hard to palpate. Pushing or pulling on the flexed leg, as well as rotation of the femur, will elicit pain, or, if the case is advanced and the destruction has been such as to destroy the direct connection between the femur and the pelvis, a laxity of the joint will be observed. In comparing the tension of the adductor muscles, it will be found that the affected limb is in a state of rigid contraction. An attempt at placing the heel over the opposite hip joint has been absolutely impossible in all true tubercular inflammations that have come under my observation.

The duration of tubercular hip joint diseases is practically never less than two years, and the general course of the disease has been divided into many stages, periods and conditions. Suffice it to say that in the early days of the disease the diagnosis may depend upon lameness, pain, inability to place the heel over the opposite hip joint, induration and thickness about the joint, muscular spasm of the adductors, reaction following the administration of tuberculin and an afternoon rise of temperature.

As the disease progresses and the limitation of

motion increases we get the arching of the spine; upon placing the limbs side by side we find the affected limb apparently longer than the healthy one. (See Fig. 3.) This lengthening of the limb is due to abduction; that is, motion of the joint has now entirely ceased and the thigh joins the pelvis at an obtuse angle, held there immovable by muscular spasm. The sub-spinous tissues are tense and unyielding; the adductors are in a state of rigid contraction.

When a leg has temporarily become ankylosed at about twenty degrees abduction it is easy to see that in order to place the two limbs parallel to each other it is necessary for the movable limb to accommodate itself to the immovable one; so, in Fig. 3, you will observe that the axis of the femur joins the horizontal axis of the pelvis at an obtuse angle, while the axis of the healthy limb joins the horizontal axis of the pelvis at an acute angle.

To place the limbs in a general line with the trunk, a tilting of the pelvis is necessary, and it is this tilting which gives the apparent lengthening of the limb. This stage of apparent lengthening is very transitory and disappears as the disease progresses; whenever it is encountered it is a sure indication that the onset of the disease is comparatively recent.

The tendency of prolonged irritation and inflam-

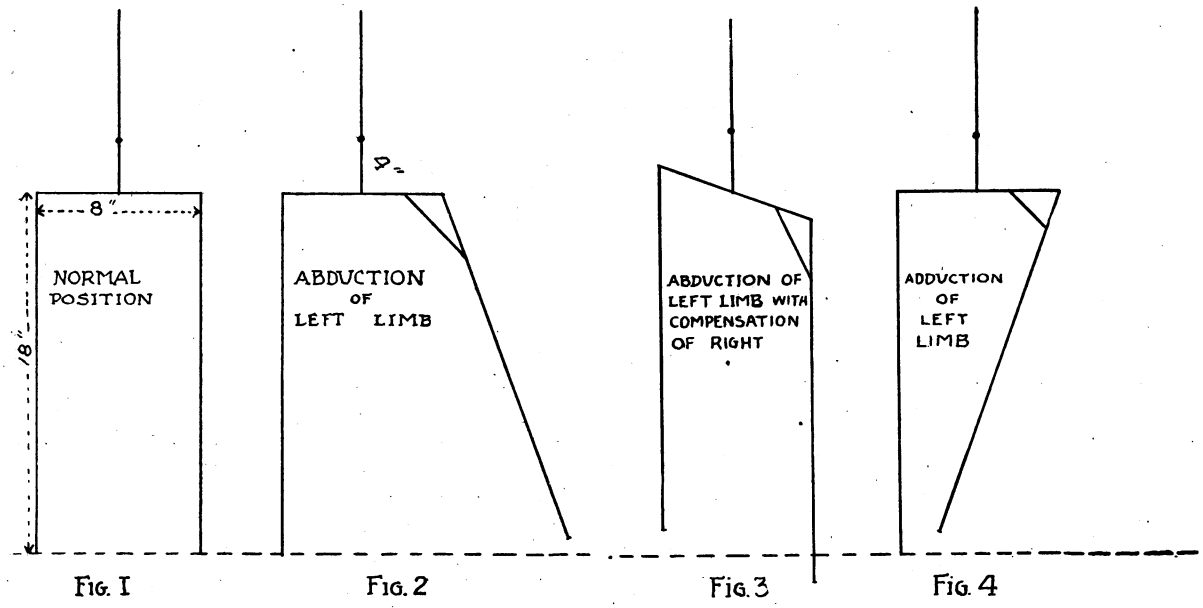

Fig. 1 Fig. 2 Fig. 3 Fig. 4

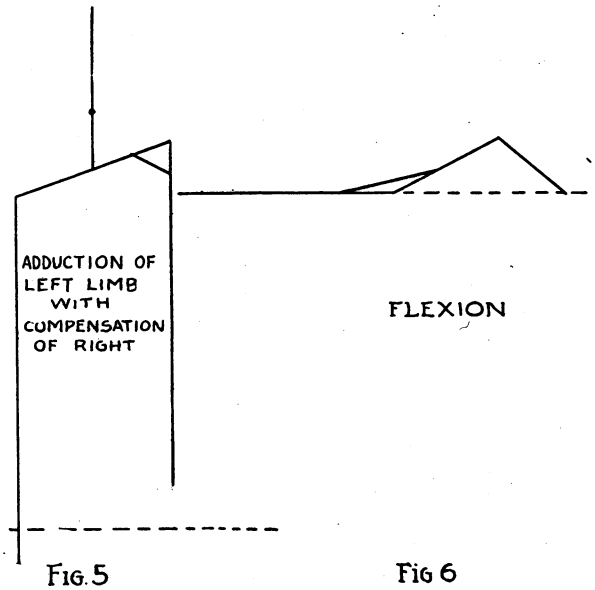

Fig. 5 Fig 6

mation of the hip joint is for the limb to become adducted and flexed, which can also be said of practically every pathological state of the hip joint, congenital dislocation, traumatism in the adult, fractures of the neck and coxa vara. The condition is very readily explained; inflammation causes muscular spasm wherever it occurs in the body, as seen in appendicitis or in an infected gall bladder. A general spastic condition of the muscles of the hip joint causes adduction and, frequently, flexion, because the adductors are many times as strong as the abductors and moderate flexion of the hip joint relaxes practically all of the muscles about it. This is one of the conditions which we have constantly to combat in the treatment of the disease. Adduction gives the opposite result to abduction; that is, apparent shortening. (See Fig. 5.) The axis of the femur joins the transverse axis of the pelvis at an acute angle; all motion is absolutely lost through muscular spasm and, when the limbs are brought parallel to each other and placed in a general line with the trunk, it again becomes necessary for the movable limb to accommodate itself to the immovable one; the spine accommodates itself also to the immovable joint and the pelvis is tilted, the affected side up and the well side down. This is the real cause of the apparent shortening. (See Fig. 5.)

It is to be distinctly understood that the lengthening and the shortening is only apparent; that, in either case, the actual measurements from the anterior superior spinous process to the internal malleolus, are the same in both limbs, but the apparent shortening can be determined by measuring from the umbilicus to the internal malleoli. If the affected limb measures longer than the healthy one, it is in a position of abduction; if shorter, adduction; the degree depending upon the difference in the length of the limb.

When treating a case of hip joint disease it is interesting to know the amount of abduction or adduction present. This knowledge is obtained in several ways—one by the use of an instrument known as a goniometer, which is placed, one limb over the transverse axis of the pelvis, the other following the axis of the limb. The number of degrees of abduction or adduction can then be read. Another method is by using "Lovett's Table," which is given in all modern text books.

Flexion—The amount of flexion can readily be determined by placing one limb of the goniometer on the table, the other in the axis of the femur, while the limb is held in such a position that the lumbar spines touch the table. Another method is by the use of the "Kingsley's Table," which can be found in the text books.

Next to adduction, flexion is the most troublesome symptom and requires constant attention in order to keep the leg from becoming deformed. (See Fig. 6.)

Method of Measuring—The following method is a generally accepted standard: The anterior superior spinous processes are located and the skin is marked; next the upper margin of the patella is found and marked on the skin. With a tape the distance between the patella and the anterior superior spinous process is determined. This distance is divided in half, and wherever that point may be the thigh is marked. Next the internal malleolus is marked. Both limbs are marked alike.

To facilitate the work, certain abbreviations have been accepted; for example, in measuring the right limb the first measurement, after the limbs have been placed side by side on a level surface, is from the anterior superior spinous process to the internal malleolus and is designated by R. A.; the next measurement, from the umbilicus to the internal malleolus and is designated by R. U.; the next, the circumference of the thigh, which is designated by R. T.; the circumference of the knee by R. K.; the circumference of the calf by R. C.; A. G. E. indicates the angle of greatest extension; A. G. F. the angle of greatest flexion. A. S. P. distance between anterior superior spinous processes, and R. B., which indicates Bryant's line, the distance between the level of the anterior superior spinous processes and the top of the great trochanter. It is customary to write the R. A., R. U., R. T., R. K., R. C., A. G. E., A. G. F., A S. P. and R. B. in one line, leaving space enough between each for writing the figures. The measurements of the left leg, which are indicated by L. A., L. U., etc., are placed immediately beneath those of the right, so that the difference in different measurements becomes very apparent. This is most essential, as the different measurements are only relative; for example, the measurements of the diseased limb are compared with those of the healthy limb.

Practically the only symptoms of tubercular abscess formations are fluctuation and swelling. It is usually not until a mixed infection occurs that pain, a rise in temperature and symptoms of sepsis manifest themselves.

TWO ANOMALIES OF THE SIGMOID COLON RESEMBLING DIVERTICULA.

By J. C. BLAIR, M. D. (From the Hearst Anatomical Laboratory of the University of California.)

Much work has been done of late upon the topographical relations of the various abdominal organs, and many points of theoretical and practical importance have been brought to light. One result of this work has been to emphasize the great variation which the different segments of the large intestine present both in form, position and size, and especially is this true in those of the sigmoid segment. This portion of the intestine, with its long mesentery, its narrow base and consequent freedom of motion, shows by far the greatest departures from the normal and offers many diagnostic difficulties.

Diverticula of the intestine are also attracting more and more attention, both medically and surgically, and although the following two cases do not prove to be fully developed diverticula, they still offer some points in the development of these conditions which may be of sufficient interest to warrant their presentation.